STATE OF MICHIGAN
IN THE SUPREME COURT

APPEAL FROM THE COURT OF APPEALS
(Fitzgerald, P.J., and Neff and White, JJ.)

MICHIGAN CHIROPRACTIC COUNCIL and the MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners/Appellees,

vs.

COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE SERVICES,

Respondent/Appellant,

and

FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY,

Intervening Respondents/Appellants.
_____/

Supreme Court Docket Nos. 126530 and 126531

Court of Appeals Docket Nos. 241870 and 241874

Ingham County Circuit Court Case No. 01-93481-AA

BRIEF OF *AMICUS CURIAE* PPOM, L.L.C., IN SUPPORT OF INTERVENING RESPONDENTS/APPELLANTS

PROOF OF SERVICE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

STATEMENT OF ORDER APPEALED FROM AND RELIEF SOUGHT

For purposes of this brief, *amicus curiae* PPOM, L.L.C., a Delaware limited liability company, adopts the Statement of Order Appealed from and Relief Sought submitted by intervening respondents/appellants Farmers Insurance Exchange and Mid-Century Insurance Company.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

For purposes of this brief, *amicus curiae* PPOM, L.L.C., adopts the Statement of Facts submitted by Farmers Insurance Exchange. As necessary, however, additional facts are included in the following sections of this brief.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

I. WHAT IS PPOM, L.L.C.?

Started in 1984 with just 350 participating providers and 2 hospitals, PPOM, L.L.C., ("PPOM") is now the largest independent preferred provider organization ("PPO") in the Midwest, with more than 55,000 participating providers and 450 participating hospitals in Michigan, Ohio, and Indiana. In Michigan alone, 18,202 physicians (70% of the state's physicians) and 181 hospitals (approximately 95% of the state's hospitals) are PPOM providers, as well as 7,895 other health care service providers, which include mental health and substance abuse hospitals, long term acute care hospitals, and rehabilitation hospitals. PPOM's health care network extends to parts of Wisconsin, Illinois, and Kentucky, and its multi-state presence ensures access to preferred local providers, as well as continuity of care and quality management across state borders.

PPOM is unique because it is among the first health care organizations in the United States to receive Health Network Accreditation with Provider Credentialing from the American Accreditation HealthCare Commission/URAC, which is the nation's premier accrediting body for PPOs. Health Network Accreditation is the highest recognition of quality within the PPO industry today. It demonstrates PPOM's network quality based on nationally accepted benchmarks in the areas of provider participation and network management, quality management, provider credentialing, and member participation and protection.

Although the structures of PPOs vary widely, PPOs share basic attributes. A PPO is not an insurer. Instead, PPOs work with health insurers to effectuate cost savings, thus benefiting both health care consumers and participating health care providers. Pursuant to the basic PPO

model, participating health care providers contract to offer medical services and care to PPO enrollees on a fee-for-service basis, in accordance with negotiated reimbursement levels. Enrollees benefit from this arrangement in two ways. First, because participating health care providers agree to render services for fixed fees, thereby circumscribing the practice of billing for medical services well above cost, PPO enrollees pay lower coinsurance payments. Second, enrollees benefit because most PPOs, like PPOM, employ stringent quality care mechanisms to ensure that enrollees obtain the highest quality, appropriate medical services for reasonable prices. In turn, medical providers benefit from this arrangement in the form of increased patients and, perhaps more significantly, timely payment for medical care services rendered. Indeed, because of their proven benefits, PPOs represent the fastest growing health care delivery system model in the United States. As health care costs rise and employers search for innovations to reduce the cost of health insurance and still allow their employees to obtain quality health care, PPOs will undoubtedly continue to grow and expand. PPOM's comprehensive network in Michigan, encompassing 95% of the state's hospitals and 70% of its physicians, demonstrates the widespread acceptance of managed care among providers, employers, and health care consumers.

II. THE CONTROVERSY AT HAND

Recognizing the cost benefits of managed care and, in particular, the PPO model and PPOM's significantly large network of participating health care providers, Farmers Insurance Exchange and Mid-Century Insurance Company (collectively, "Farmers") offered Farmers' no-fault insurance policyholders a "Preferred Provider Option Endorsement" ("PPO option"). Entirely voluntary, the PPO option enabled policyholders to reduce their premiums if they agreed

to receive auto health services from the thousands of PPOM medical care providers in Michigan. In the unlikely event that one of Farmers' no-fault insureds who chose the PPO option ventured outside PPOM's wide-ranging, comprehensive network to obtain medical treatment, the insured paid a deductible and qualified for reimbursement at PPOM network rates for any services rendered by the out-of-network provider. Farmers initially offered its PPO option in 2000.

In August 2000, petitioners-appellees, Michigan Chiropractic Council and the Michigan Chiropractic Society, two health care provider groups with their own acute interests in preserving their patient base and current fee structure, petitioned the Insurance Commissioner to commence formal administrative proceedings against Farmers, alleging that Farmers' PPO option violated the Michigan No-Fault Act, MCL 500.3101 *et seq.* In a well-reasoned and legally sound Order, the Insurance Commissioner deemed Farmers' PPO option firmly consistent with the No-Fault Act and, thus, denied the request for a formal hearing. In essence, the Insurance Commissioners' order endorsed Farmers' PPO option as a no-fault insurance product beneficial to the state's residents, and specifically those members of the driving public who lack primary health insurance coverage that may be coordinated with no-fault coverage under MCL 500.3107a (**Exhibit 1**).

Subsequently, the Ingham Circuit Court and, on further review, the Court of Appeals, rejected the Insurance Commissioner's conclusions, striking down Farmers' PPO option and, indeed, all conceivable future managed care options that may be offered in no-fault insurance policies (**Exhibits 2** and **3**, respectively). The Court of Appeals' decision is erroneous in two respects. First, the decision rests on a construction of the Michigan No-Fault Act that finds no support in the clear statutory provisions of the Act, its legislative history, or the case law

interpreting the Act. Second, although the Court of Appeals pointedly disapproved of problematic penalty provisions in the Farmers' policy that could affect insureds who step outside PPOM's provider network for health care, the Court of Appeals' unnecessarily broad, sweeping decision discourages no-fault insurers from attempting to draft other possibly acceptable managed care options that do not contain similar penalty provisions. Thus, not only does the decision misconstrue the import of the No-Fault Act, it effectively renders **all** managed care options violative of the Act, even those that permit the insured to use the PPO network voluntarily, with no penalty for treating with out-of-network health care providers. Because the Court of Appeals' decision is legally flawed and too broad, this Court should reverse it or, at the very least, rein in its scope to allow insurers to draft future PPO options as a viable no-fault insurance product for Michigan consumers.

III. PPOM'S REQUISITE INTEREST IN THE ISSUES BEFORE THIS COURT

PPOM contends that it has the requisite interest in the issue(s) now before this Court and thus invites this Court to consider the arguments and views expressed in this *Amicus* Brief. First, PPOM has a clear, direct interest in the outcome of this litigation because it is the Midwest's largest independent PPO and the PPO with which Farmers partnered to provide services to its policyholders who voluntarily chose the PPO option. Due to the Court of Appeals' condemnation of managed care in a no-fault context, PPOM and the multitude of other PPOs may not partner with no-fault insurers to provide health care management services to insureds that voluntarily choose managed care options for their auto-related health care needs in exchange for lower premiums. Moreover, the unduly expansive sweep of the Court of Appeals' opinion will deter other no-fault insurers from implementing voluntary managed care options and

prevents policyholders from choosing existing options and other options that may be formulated in the future.

The Court of Appeals' decision has also resulted in additional provider contracting and reimbursement issues for PPOM (and, presumably, other similarly situated managed care companies) and its network of health care services providers. PPOM network providers now cite the adverse decisions by the Ingham Circuit Court and the Court of Appeals as a basis for claiming charges over and above pre-negotiated charges for services rendered to Farmers no-fault policyholders pursuant to the PPO option. Additionally, other health care providers will hesitate to enter into contracts with PPOM and become PPOM network providers based on the Court of Appeals' adverse decision, which dilutes PPOM's bargaining power as a diversified PPO with influence in the automobile no-fault market. At a very basic level, the Court of Appeals decision negatively impacts PPOM's proprietary interests and those of the managed care community as a whole.

PPOM, like every citizen of Michigan, both individual and corporate, has a marked interest in the development and realization of solutions that check the precipitous rise of health insurance costs and, as a directly related matter, the costs of no-fault insurance. Rather than beleaguer this Court with any further description of the costs crisis impacting medical and no-fault insurance in this country and the State of Michigan, PPOM refers this Court to the Brief of *Amicus Curiae* Insurance Institute of Michigan, which succinctly and ably describes the current insurance crisis in this State and nationwide, and details its crippling effect on the consumers of health care and no-fault insurance. PPOM asserts that it and all of Michigan's citizens share an

interest in encouraging health care consumers, providers, and insurers to develop new and innovative ways to control the costs of health care and insurance.

For these reasons, PPOM contends that it has significant interests in the issues presently before this Court and requests that this Court consider the argument and views expressed in this *Amicus* Brief.

ARGUMENT

I. THIS COURT SHOULD REVERSE THE COURT OF APPEALS' DECISION BECAUSE, IN ADDITION TO BEING LEGALLY FLAWED, IT IS TOO BROADLY WRITTEN AND, THUS, READILY SUSCEPTIBLE TO INTERPRETATIONS THAT WOULD PRECLUDE NO FAULT INSURERS FROM OFFERING POLICYHOLDERS NON-PENALIZING PPO OPTIONS

A. The Arguments Of Farmers And *Amicus Curiae*, Insurance Institute Of Michigan, Amply Support This Court's Decision To Reverse The Court Of Appeals' Decision

PPOM agrees with and adopts the arguments advanced in support of Farmers' Brief on Appeal, as well as the issues and arguments raised in the Brief of *Amicus Curiae* Insurance Institute of Michigan. While PPOM does not wish to burden this Court with further iteration of those parties' positions, it will briefly summarize the main points of those compelling arguments.

First, Farmers and the Insurance Institute of Michigan ("Insurance Institute") – and PPOM by adoption – argue correctly that this Court should reverse the Court of Appeals' decision because there is a pressing need to resolve the inherent conflict between the Court of Appeals' decision and the Supreme Court's decision in *Tousignant v Allstate Insurance Co*, 444 Mich 301; 506 NW2d 844 (1993). In *Tousignant*, the Supreme Court expressly recognized that the Michigan No-Fault Act permits an insured to **voluntarily** relinquish his or her choice of

physician and facility when the insured opts to coordinate no fault coverage with his or her health care insurance under MCL 500.3109a. *Id.* at 310-313. Contrary to the arguments of the Michigan Chiropractic Council and the Michigan Chiropractic Society, nothing in *Tousignant* limits the decision's application solely to situations involving coordination under MCL 500.3109a. Indeed, if, in the instant matter, the Court of Appeals correctly held that the Michigan No-Fault Act seeks to foster an unfettered choice of medical providers and "fee-for-service" medical care, then the Supreme Court in *Tousignant* **should have** concluded that MCL 500.3109a mandates that no-fault insurers pay all costs incurred when an insured who has coordinated his or her no-fault coverage with HMO health coverage elects to seek treatment outside the boundaries of his or her managed care health plan. It is significantly revealing that this Court did not travel this route and held instead that a no-fault insured may legally choose "to relinquish choice of physician and facility" in opting for coordinated coverage and the associated no-fault premium reduction. *Id.* at 310-313. Because the Court of Appeals' decision eliminates the insured's right to opt in or opt out, i.e., "to relinquish choice of physician and facility," it subverts the reasoning of *Tousignant* and, accordingly, must be reversed or otherwise brought into harmony with this Court's existing precedent on the issue of choice.

Second, as the Insurance Institute argues convincingly, the premium discount offered under a PPO option, where it is "reasonably calculated to reflect the reduced cost and expenses expected from the program," furthers the constitutional mandate that no-fault insurance be affordable and available to all drivers in Michigan. See *Shavers v Attorney General*, 402 Mich 554, 559-560; 267 NW2d 72 (1978). Third, the Insurance Institute also correctly notes that a managed care option permits the thousands of drivers in Michigan who lack health care

coverage and, concomitantly, the ability to realize no-fault cost savings by coordinating their no-fault coverage with their health insurance, to purchase their no-fault coverage on a group basis and avail themselves of the resultant savings.

While these considerations amply support this Court's decision to reverse the Court of Appeals' decision, the far-reaching, possibly unintended implications of the Court of Appeals' decision compel this Court's careful review of the **scope** of the decision, in addition to its flawed legal underpinning.

B. The Court Of Appeals' Decision Is Too Broadly Written And, Consequently, Prohibits No-Fault Insurers From Writing Policies That May Provide "Acceptable" Managed Care Options That Do Not Penalize Policyholders Who Seek Medical Care Outside The Managed Care Network

The Court of Appeals' decision is resoundingly absolutist and essentially prohibits no-fault insurers, under all circumstances and irrespective of policy language, from offering managed care options, including those that do not penalize insureds who seek medical care outside the managed care network. Granted, the Court of Appeals **attempted**, to a limited extent, to confine the scope of its decision to the unique language and penalty provisions of the Farmers' policy. For example, the Court of Appeals closely scrutinized the specific language of the PPO option, voiced its disagreement with purportedly misleading language in the policy and the penalty provisions of the PPO option, and stated in the final paragraph of its opinion that it affirmed the circuit court's disposition of the matter because "the PPO endorsement **at issue** is inconsistent with the act" (**Exhibit 3**, p 11 (emphasis added)).

Unfortunately, the general tenor of the Court of Appeals' opinion casts a pall over **any** future managed care options, even ones that omit penalty provisions like those contained in the

Farmers' policy or are otherwise consistent with this Court's decision in *Tousignant*. When the Court of Appeals stridently states that "[m]anaged care, and in particular, the PPO option at issue, fundamentally alters the essential premise of Michigan no-fault insurance and is inconsistent with the no-fault act general benefits provisions," it becomes virtually impossible to limit application of the Court's opinion to the specific language of the PPO option at issue. In effect, the Court of Appeals' opinion completely forecloses insurers' attempts to incorporate managed care concepts into no-fault insurance policies, even though managed care and PPOs specifically define health care today and offer a range of provider choice that is, for all intents and purposes, coextensive with the choices available on the medical market today. This flawed aspect of the Court of Appeals' decision mandates this Court's reconsideration of both the underpinnings and scope of that holding.

Further, while the Court of Appeals' concern with the $500 deductible provision of the Farmers' policy and the out-of-network payment provision motivated much of its opinion, the appellate court also found that the Farmers' policy contained misleading provisions and partially based its decision to affirm on these purportedly misleading provisions. As explained below, the Farmers' policy is not misleading at all. Thus, if this Court were to reject the PPO option because of its penalty provision, this Court could still reverse the Court of Appeals' holding that the policy's language concerning the discounts available to policyholders is somehow misleading or confusing.

1. Harsh Penalties Are Not A Necessary Aspect Of All Conceivable Managed Care Options

Aside from the (incorrect) aspect of the Court of Appeals' decision that found the PPO option in direct conflict with MCL 500.3107, the decision also found fault with the "severe

penalty provisions" contained in the PPO option. Under the PPO option, these penalties arose if the insured sought medical care from providers outside the large PPOM network:

> [I]f a policyholder elects to go out of network for care, they [sic] will be required to pay:
>
> - a $500 deductible (which is not applicable to those who stay in network for care)
>
> - any charges by the provider beyond which would have been reimbursed according to the carriers' usual and customary fee schedule.

These penalties significantly influenced the Court of Appeals' ultimate decision:

> Further, Farmers' PPO option carries with it severe penalty provisions, imposed when a no-fault claimant acquires out-of-network services despite the policyholder's agreement to the PPO endorsement. These penalties clash with no-fault precepts, and further convince us that the endorsement must be rejected as inharmonious with the no-fault regime established by the Legislature. *Cruz*[*v State Farm Mutual Automobile Ins Co,* 466 Mich] 595-596, 598[; 648 NW2d 591 (2002)]. [**Exhibit 3**, p 11.]

To the extent that the Court of Appeals read the penalty provisions in the Farmers' PPO option as justifying a blanket rejection of the PPO option as a whole, the Court of Appeals erred. In *Cruz*, *supra*, this Court stated that innovations like the PPO option at issue "are only precluded when they clash with the rules the Legislature has established for such mandatory [no-fault] insurance policies. . . . [A policy provision] that contravenes the requirements of the no-fault act by imposing some greater obligation upon one or another of the parties is, **to that extent**, invalid." *Id.* at 598 (emphasis added). Thus, if the Court of Appeals found the Farmers' PPO option's increased deductible provision antithetical to "no-fault precepts," it should have stricken that offending provision. *Cruz*, *supra*.

Considered apart from the provision imposing an increased deductible on those who treat outside PPOM's network, the remaining portions of Farmer's PPO option completely harmonize with the Court of Appeals' formulation of the policies underlying the Michigan No-Fault Act, as well as this Court's pronouncements in *Tousignant* and *Cruz*, *supra*. As discussed, the Court of Appeals' decision emanated from its determination that the No-Fault Act seeks to guarantee insureds the right to select providers:

> In *Tousignant*, the no-fault claimant had coordinated coverage under a managed care health maintenance organization (HMO) provided through her employer, which as the PPO in this case, required that treatment be obtained from designated physicians or facilities. The Court recognized that a no-fault insured generally has a wide choice of physicians and facilities. . . .
>
> Managed care under the coordinated health and accident coverage of §3109a is clearly distinguishable in concept from the general no-fault medical benefits under subsection 3107(1)(a), as are the legislative purposes underlying these provisions. **General no-fault benefits under subsection 3107(1)(a) offer a range of choice. Managed care, under a PPO plan, offers only limited choice. The substitution of a PPO plan for no-fault general medical benefits is therefore not in keeping with the no-fault act.**
>
> * * *
>
> "The most striking feature of Michigan's no-fault system is that, apparently alone among the no-fault states, it provides unlimited lifetime medical and rehabilitation benefits." House Legislative Analysis, HB 4156, July 29, 1993, p 1. "The no-fault act preserves to the injured person a choice of medical services and providers." **On the contrary, inherent in the concept of managed care is limited choice.** [**Exhibit 3**, pp 8-9 (emphasis added).]

Even if the Court of Appeals correctly captured the intent of the Michigan Legislature, its decision evidences a patent misunderstanding of the current scope of managed care and the dramatic change in circumstances since the enactment of the No-Fault Act in 1972.

In light of the realities of managed care today, and PPOM's wide network of health care providers in particular, the Court of Appeals' concern for freedom of choice is misplaced. While

the Court of Appeals' statement that "inherent in the concept of managed care is limited choice" may have been accurate in the early years of managed care, the same cannot be said today, considering PPOM's unprecedented level of provider participation. As stated previously, in Michigan alone, 70% of the state's physicians and approximately 95% of the state's hospitals are PPOM participating providers. This extensive and unprecedented participation undermines any assertion that "inherent in the concept of managed care is limited choice," especially in view of the explosive growth of PPOs and the anticipation that even more medical providers will choose to become PPOM participants.

As importantly, under the terms of the Farmers' PPO option (again, disregarding the increased deductible penalty), policyholders may choose to receive services from any medical care provider within the state, not just those that are PPOM participants. This is fully consonant with the Court of Appeals' conception of the Michigan No-Fault Act as a statutory scheme that preserves unbridled choice of medical providers. Inexplicably, the Court of Appeals ignored the freedom of choice incorporated in the PPO option and, instead, focused on the provision of the PPO option requiring the policyholder to pay for any charges exceeding the carriers' usual and customary fee schedule. It seemingly concluded that the limitation on Farmers' reimbursement obligation somehow trammels the No-Fault notion of "fee-for-service" medical care embodied in MCL 500.3107 and MCL 500.3157, a determination that can only be attributed to the Court of Appeals' misreading of these two statutes.

As may be gleaned from a cursory reading of the statutes, the Legislature intended to inject into the no-fault system a modicum of reasonableness that would ensure its survival:

> (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:

> (a) Allowable expenses consisting of all **reasonable** charges incurred for **reasonably** necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. [MCL 500.3107 (emphasis added).]
>
> * * *
>
> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a **reasonable** amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance. [MCL 500.3157 (emphasis added).]

Absent limitations on the reimbursement obligations of insurers, who are now **required to** offer specified levels of coverage, providers could exploit the opportunities presented by the system and either cause its demise or accelerate an increase in health care costs.

Rather than guaranteeing insureds the right to choose or providers the right to treat, the statutes principally seek to regulate the ability of insureds to choose whomever they please, regardless of cost, as their medical providers. They obligate insurers to pay only "reasonable charges" for "reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." Although these provisions enable an insured to obtain full reimbursement for "reasonable charges" for "reasonably necessary services," this limiting language "eliminates" those providers who fail to satisfy such conditions by charging unreasonable prices and providing unnecessary services. Consequently, by their very language, these statutes effectively exclude certain providers and evidence that the Michigan Legislature never intended to grant insureds an unfettered right to select any provider. To serve the policy underpinnings of the No-Fault Act and promote cost containment, courts should encourage

insureds to negotiate the scope of the provider group and limit confusion and uncertainty as to their ability to obtain reimbursement of provider charges, particularly in those instances where the outcome is reduced premiums.

Even if the No-Fault Act seeks to guarantee "reasonable" fees to providers, it simply is not accurate to state that Farmers' PPO option prevents out-of-network health care providers from recovering the "reasonable" fee for the services they provide. Again, **70% of Michigan physicians participate in PPOM, as well as approximately 95% of the state's hospitals**. To say that the pre-negotiated fees that PPOM network physicians and hospitals receive are not "reasonable" charges is to ignore that a significant majority of the state's physicians and nearly all of its hospitals have agreed already that the pre-negotiated fees **are** reasonable. Thus, under the PPO option, a non-participating physician will be paid a reasonable fee for the service he or she provides to a Farmers' no-fault policyholder that has chosen the PPO option. There is nothing objectionable about requiring the policyholder to pay any portion of the cost exceeding the reasonable pre-negotiated fee because, even under MCL 500.3107 and MCL 500.3157, a no-fault insured remains liable for any portion of a medical fee that is over and above the reasonable fee for that service. Without the penalty provisions, the Farmers' policy is fully consistent with the Michigan No-Fault Act, even as the Court of Appeals envisions the Act and its underlying policies.

2. Farmers' Policy Language is not Misleading or Confusing

Perhaps overly-sensitized to the policy's language due to the high deductible set forth in the PPO option (which undeniably violates MCL 500.3109(3)) and its dislike for the PPO option as a whole, the Court of Appeals also found "further basis for reversing the commissioner's

decision" in the Farmers' policy's language explaining the various discounts available to policyholders who choose (i) the PPO option, (ii) the higher deductible under MCL 500.3107, or (iii) coordinated coverage under MCL 500.3107a. In a conclusory manner, the Court of Appeals deemed the policy language misleading and confusing, despite language of the policy unequivocally stating that, by selecting the PPO option, policyholders forego other premium reductions in exchange for the largest premium discount available. Furthermore, nothing in the Michigan No-Fault Act prevents insurers from requiring policyholders to elect one of several available premium discounts. Because the policy is written in clear and understandable language that comports with the No-Fault Act, this Court should reject the Court of Appeals' concern for the policy's "potential for deception" as a basis for reversing the Insurance Commissioner's decision.

Contrary to the Court of Appeals' jaundiced reading of the Farmers no-fault policy, the policy's terms accurately apprise policyholders of the discounts they will obtain and the discounts they will forego if they choose certain options. It uses plain and ordinary language to describe the premium options and discounts associated with the PPO option, the $300 deductible endorsement, and traditional coordinated coverage pursuant to MCL 500.3109a:

> (c) Preferred Provider Option Endorsement --
>
> Policyholders who elect the Preferred Provider Endorsement will receive a 40% reduction on their PIP rate. The endorsement requires the insured to choose a physician from our captured network, Preferred Providers of Michigan, to manage health care in the event of a covered injury.
>
> The E7143 will not be allowed if the option is selected. The other insurance credit will not be allowed if this option is selected.

> All policies in the household are required to carry the PPO option if the insured selects this option. Disclosure form 51-0693 must be signed by the insured for each policy in the household to verify selection of the PPO option.

The E7143 referenced in the PPO option clearly states:

> (a) $300 Deductible P.I.P. (E-7143) --
>
> Policyholders who elect to take the "Endorsement Establishing Deductible and Waiting Period" will receive a 15% reduction from the P.I.P. rates. The endorsement provides a $300 medical deductible and a 7 day waiting period on benefits for "work loss". (Not available if the other insurance rate credit is taken.)

Finally, the provision in the policy granting various credits reads:

> (b) Other Insurance Rate Credit --
>
> P.I.P. rates are discounted 25% if the insured elects their [sic] P.I.P. coverage to be secondary over other A & H medical insurance or another 10% if he elects his weekly indemnity coverage to be secondary to other wage continuation coverage. Thirty Five percent (35%) will be deducted if both coverages are secondary.
>
> These credits are applied to the reduced rate after other credits such as second care discount, etc., have been applied.
>
> If this option is selected, the $300 deductible credit under the E-7143 described in (a) above will not be allowed.

These provisions do not invite any uncertainty respecting the alternative premium discounts available. There exists no credible basis for the Court of Appeals' conclusion that the "'exchange system' of premium discounts renders illusory the touted reduction in the cost of insurance to policyholders" (see **Exhibit 3**, p 8). In fact, the policy language represents a clear and straightforward explanation of the various programs available, their associated premium reductions, and their mutual exclusivity. The policy clearly states that choosing the PPO option results in a 40% discount to policyholders, but forecloses election of other available premium discounts. The "exchange system," as the Court of Appeals termed it, is neither hidden in the

policy's "small print" nor is it set apart from the PPO endorsement where a policyholder may fail to see it. A policyholder choosing the PPO option would readily understand that he or she could not "stack" other options that might result in premium discounts. Despite that, policyholders choosing the PPO option still receive the largest premium discount offered in the Farmers' policy, a 40% reduction, compared to the 15% premium discount offered in conjunction with the $300 deductible option, and the maximum 35% discount available to those who choose coordinated coverage. There is nothing "illusory" about the substantial savings offered in connection with the PPO option.

The Court of Appeals' opinion implies that, under the No-Fault Act, insurers must allow policyholders to combine premium discount options if these options appear in a single insurance policy. To the contrary, the Act states that insurers "may" offer, "at appropriate reduced premium rates, a deductible of a specified dollar amount which does not exceed $300 per accident," MCL 500.3109(3), and that insurers must "offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured," MCL 500.3109a. In accordance with the Act, the Farmers' policy offers both options at appropriately reduced rates. MCL 500.3109 nowhere requires an insurer to permit a policyholder to combine all available premium options and discounts to arrive at the lowest possible premium payment. If that were true, insurers actually would be discouraged from offering premium discounts other than the mandated coordinated coverage option, because additional options could reduce premium payments to levels that could jeopardize insurers' reasonable business expectations. Such a restraint on flexibility and innovation cannot be the intent of the Michigan No-Fault Act.

In sum, the policy language clearly apprises policyholders of the premium reduction options available to them. The very real savings associated with the PPO option are not "illusory" in any sense. Moreover, the policy language is consistent with the No Fault Act, which does not require insurers to permit policyholders to combine discount options to arrive at the lowest possible premium payments, which quite possibly could frustrate insurers' legitimate commercial expectations.

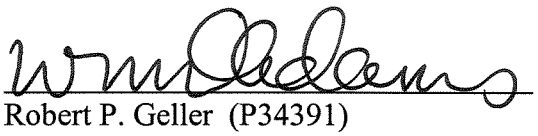
CONCLUSION

This Court should reverse the Court of Appeals' decision, at it is based on a flawed reading of Michigan's No-Fault Act, one that subverts the Supreme Court's reasoning in *Tousignant*, *supra*, in the name of a "freedom of choice" nowhere mentioned or implied in the Michigan No-Fault Act. Ironically, the Court of Appeals' decision, while touting choice, denies insurance consumers the choice of electing a managed care option and lowering their premiums. Further, the Court of Appeals' decision sweeps too broadly by invalidating **all** managed care provisions, even those that do not contain penalty provisions similar to that in the Farmers' policy. Even if this case is affirmed, this Court must still rein in the scope of the Court of Appeals' decision, which negatively impacts Michigan insurers and insureds, especially those insureds that lack health insurance and the concomitant ability to coordinate coverage under the No-Fault Act at reduced premiums. Accordingly, *amicus curiae* PPOM, L.L.C., respectfully requests that this Court reverse the Court of Appeals' decision or, in the alternative, resolve the issues in a manner that would allow no-fault insurers to write policies providing "acceptable"

managed care options that do not penalize policyholders who seek medical care outside the managed care network.

Respectfully submitted,

HERTZ, SCHRAM & SARETSKY, P.C.

By: 

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STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DIVISION OF INSURANCE

Before the Commissioner of Financial and Insurance Services

In the matter of the Petition for Contested Case filed by the Michigan Chiropractic Society and the Michigan Chiropractic Council against Farmers Insurance Group

Order No. 01-008-M

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Issued and entered
this 23rd day of January 2001,
by Frank M. Fitzgerald
Commissioner of OFIS

ORDER DENYING IN PART PETITION FOR CONTESTED CASE HEARING

I
BACKGROUND

On August 11, 2000, the Commissioner of the Office of Financial and Insurance Services received a "Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" (the Original Petition) from the Michigan Chiropractic Society and the Michigan Chiropractic Council (collectively, the Petitioners). Petitioners alleged generally that Farmers Insurance Group (the Respondent, or Farmers) was violating the Insurance Code, MCLA 500.100 *et seq.* by offering its policyholders a "Preferred Provider Option Endorsement." Petitioners alleged that this Preferred Provider Option violates the rights of insureds (Count I), violates the rights of medical care providers (Count II), and violates section 3109 of the Insurance Code (Count III). The Original Petition requests that the Commissioner investigate Farmers' policy and practice,

commence an administrative hearing against Farmers under Chapter 20 of the Insurance Code, and disapprove the disputed endorsement under section 2236 of the Insurance Code. The Original Petition also requests that the Commissioner petition the Attorney General's office to bring antitrust charges against Respondent.

Pursuant to Rule 4(1)(b) of the Insurance Bureau hearing rules, AACS 1983, R. 500.2104(1)(b), the Commissioner, through his staff, requested that Farmers respond to the Original Petition. Farmers filed its "Response by Farmers Insurance Exchange and Mid-Century Insurance Exchange to Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated September 25, 2000. In its Response, Farmers argues that the Preferred Provider Option provides the full range of medical care required by the No-Fault Act, is consistent with the No-Fault Act's goal of providing affordable coverage because policyholders receive a substantial rate reduction for electing this option, and asserts that "numerous Michigan chiropractors have voluntarily agreed to participate, and in fact do participate, as members" of the provider network under the Preferred Provider Option. (Response, ¶¶ 2, 3 and 22) Farmers' Response requests that the Commissioner take no further action on the Original Petition.

The Insurance Division provided Petitioners with a copy of Farmers' Response. Petitioners filed their "Reply in Support of Request for Issuance of Notice of Hearing" dated October 6, 2000. Petitioners argue that the Preferred Provider Option was essentially rejected by voters when Proposal C, a referendum on 1993 PA 143, was defeated. Petitioners acknowledge that 196 chiropractors participate in the preferred provider network, but assert that when they joined, there was no Preferred Provider Option, hence those chiropractors did not agree to participate in the context of no-fault benefits.

The Insurance Division next sent both Petitioners and Respondent requests for additional information. Petitioners responded by filing a "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceeding", dated November 22, 2000, which amended the Original Petition by adding a Count IV. In Count IV they assert that Respondent's refusal to pay for chiropractic care on the grounds that "comparable" non chiropractic care is available through the primary health care coverage constitutes a pattern or practice of violating section 2026 of the Insurance Code.

Farmers also filed an additional response, received on November 30, 2000, asserting that the premium discount for electing the Preferred Provider Option was based on expected reductions in personal injury protection medical expenses and loss adjustment expenses associated with the managed care system. This included an anticipated 25% reduction in the cost of medical services obtained through the provider network, another 15% reduction resulting from utilization management, and unspecified savings from claims review.

II
ISSUES

The principal issues are:

1. Should the Commissioner exercise his discretion to commence a contested case hearing based on the assertions of the Original Petition that Respondent's Preferred Provider Option violates the No-Fault Act or the Uniform Trade Practices Act?

2. Should the Commissioner exercise his discretion to commence a contested case hearing based on the assertions of Count IV of the First Amended Petition that Respondent violates the Uniform Trade Practices Act by refusing to pay for chiropractic care under a coordinated no-fault policy where comparable care is available under the primary health care coverage?

III
ANALYSIS

The Commissioner has express statutory authority upon probable cause to "examine and investigate into the affairs" of a person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or any unfair or deceptive act or practice prohibited by sections 2001 to 2050 of the Uniform Trade Practices Act. MCLA 500.2028. Where the Commissioner has probable cause to believe that there is or has been such a violation and "that a hearing by the commissioner in respect thereto would be in the interest of the public," he may commence a hearing into the alleged violations. MCLA 500.2029. Moreover, the Commissioner has authority pursuant to section 2236 of the Code to withdraw approval of an insurance policy form that "violates any provisions of this code, or contains inconsistent, ambiguous or misleading clauses, or contains exceptions and condition that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy." MCLA 500.2236(5). Petitioners expressly assert that the Commissioner has jurisdiction in this case (Original Petition, ¶ 1, pg 1; Amended Petition, ¶ 1, pg 1) In its answer, Respondent admits the jurisdictional allegations. (Respondent's answer, ¶ 1, pg 2) Therefore the Commissioner's authority is both well-established and uncontested.

All three counts of the Original Petition challenge the legality of Respondent's Preferred Provider Option. The First Amended Petition repeats the original three counts and adds a Count IV, asserting that Respondent violates section 2026(a) and (n) of the Insurance Code by unjustifiably refusing to pay for chiropractic care where the primary health care coverage provides "comparable" non-chiropractic treatment. Respondent has not yet been given the opportunity to respond to the First Amended Petition. Because

Count IV alleges a separate violation unrelated to the first three counts, except that the Respondent is the same, it is appropriate to deal with Count IV separately. Accordingly, Respondent will be given an opportunity to answer Count IV following entry of this order and the Commissioner will respond to Petitioners' request for a hearing as to Count IV separately at the appropriate time. The analysis that follows applies to the Original Petition for contested case hearing and the first three counts of the First Amended Petition.

The essential facts are not contested. Respondent's Preferred Provider Option allows policyholders to elect to limit their choice of medical care providers in the event they suffer auto related injuries. Policyholders who elect the Preferred Provider Option receive a 40% reduction in the premium for personal injury protection coverage. If they are injured in an automobile accident, policyholders who elect the option must either get their treatment from a network of medical care providers maintained by Preferred Providers of Michigan (PPOM), or, if they go outside the network, they must pay a $500 deductible and reimbursement is limited to the amount the network pays for the service. Policyholders are not required to select the Preferred Provider Option. They may preserve a broader choice of medical care providers by declining the option and foregoing the premium reduction.

Count I

Petitioners assert in Count I of the Original Petition that the preferred Provider Option violates the rights of insureds because there is no statutory authorization for a managed care option under the No-Fault Act. They also argue that the voters rejected the concept of managed care in the context of the No-Fault Act when they defeated Proposal C, a referendum on 1993 PA 143. Further, they argue that the Preferred

Provider Option has been instituted "in a manner which causes the provision to 'unreasonably or deceptively affect the risk purported to be assumed in the general coverage in the policy', contrary to §2236." (Original Petition, ¶ 17, pg 5)

Respondent answered Count I asserting generally that the Preferred Provider Option is consistent with the legislative purpose of the No-Fault Act, that is, "to provide all reasonably necessary medical care to injured policyholders while at the same time holding down the costs of both medical care and insurance premiums for Michigan insureds." (Farmers' September 25, 2000 Response, pg 2) Farmers denies that the option is prohibited by the No-Fault Act and asserts that:

> Insureds receive no different scope or quality of medical care under the Option than they would receive outside the PPOM network. The Option merely defines the universe of providers from whom insureds may obtain medical treatment without having to pay a deductible and fee differential.

(*Id.* ¶ 18, pg 11)

Petitioners have failed to establish that Respondent's Preferred Provider Option is invalid as alleged in Count I of the Original Petition.

First, they have failed to show that statutory authorization is necessary to initiate the Preferred Provider Option. Respondent's Preferred Provider Option is not inherently inconsistent with the requirement of section 3107 that no-fault coverage include "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." MCLA 500.3107(1)(a). Adequate care can be provided through a network of competent providers covering the full range of medical needs. In fact, Respondent asserts that "[i]nsureds receive no different scope or quality of medical care under the Option than they would receive outside the PPOM network." (*Id.*) Respondent acknowledges that

the Option "neither expands nor diminishes the risks purported to be assumed in the general coverage of the policy *because those risks are established as a matter of Michigan law, pursuant to MCLA 500.3107.*" (*Id*, pp 10-11, emphasis added) In short Respondent recognizes that it is required by statute to provide "all reasonable charges incurred for reasonably necessary" treatment, and asserts that it does so through the PPOM network. Petitioners have provided no evidence that Respondent's claim is untrue.

In an October 24, 2000 letter, the Insurance Division specifically asked Petitioners for evidence that the Preferred Provider Option results in inadequate care as follows:

> Are Petitioners alleging that policyholders who elect Farmers' managed care option do not have access to a range of medical care providers within the PPOM network sufficient to adequately provide treatment for automobile related injuries? If so, please provide the Commissioner with a complete description of all of the evidence on which Petitioners rely, including the names of any witnesses, a description of their expected testimony, and copies of any documents supporting the allegation that the network is insufficient.

In response, Petitioners failed to provide any reason to believe that medical treatment available under the PPOM network is inadequate in any regard, arguing instead that "[t]o the extent Insurance Bureau staff has looked towards [Petitioners] to provide detailed evidence, such is unfair." (Memorandum in Support of First Amended Petition, pg 2) On the contrary, it would be unfair to presume that the Preferred Provider Option fails to provide the scope of coverage required by section 3107 based on Petitioners' unsubstantiated allegations. Petitioners' mere allegations, without more, do not rise to the level of probable cause. Moreover, Petitioners recognize that their position "is really straightforward and is based upon legal issues." (*Id.*) Petitioners have failed, both legally and factually, to support their claim that the Preferred Provider Option violates section

3107 and therefore requires statutory authorization.[1]

Similarly, the rejection of 1993 PA 143 by referendum does not support Petitioners' argument that the Preferred Provider Option is illegal because it requires express statutory authorization. Petitioners argue that the voters rejected "managed care" in the context of the No-Fault Act when they rejected 1993 PA 143. They also argue that the fact that no-fault insurers sought authorization in 1993 PA 143 for a managed care program demonstrates that they could not initiate a managed care option absent legislative authorization. (Original Petition, ¶¶ 14, 15, and 19) Quite to the contrary, the provision in 1993 PA 143 authorizing "clinical care management" (proposed section 3104b) was only one part of a 48-page proposal that would have changed fundamental aspects of the no-fault system. Among other things, Act 143 would have: (A) allowed policyholders to elect less than unlimited lifetime personal injury protection benefits, (B) required mandatory initial rate reductions of around 16%, (C) required the Commissioner to establish a fee schedule for medical treatment that medical care providers would be required to accept, and (D) imposed additional restrictions on lawsuits. Thus it is mere speculation to conclude that the rejection of 1993 PA 143 was a rejection of the concept of "clinical care management." It could just as easily be argued that the public rejected trading permanent loss of unlimited personal injury protection benefits for a transitory rate reduction.

Moreover, Farmers' Preferred Provider Option is different than Act 143 in another critical aspect. Proposed section 3104b in Act 143 would have allowed no-fault insurers

[1] It is important to emphasize that this would be a different case if there were probable cause to believe that the medical treatment available under the Preferred Provider Option were substandard or that it failed to cover the full range of benefits required by section 3107. However, Respondent expressly acknowledges its statutory obligation to comply with section 3107, and Petitioners have failed to provide any evidence that adequate care is not available.

to impose "clinical care management" upon unwilling policyholders. But Farmers Preferred Provider endorsement is optional. Policyholders may elect to stay with the existing fee for service arrangement. There is a significant difference between allowing *policyholders to elect* managed care and authorizing *insurers to impose* it on unwilling policyholders. Petitioners argue that the use of managed care under Act 143 was "permissive," because no-fault insurers could choose whether to initiate managed care for an insured whose PIP benefits were not expected to exceed $250,000. Therefore, they reason, the rejection of Act 143 was a rejection of "all managed care, *especially so-called voluntary managed care because managed care for amounts under $250,000 was permissive.*" (Reply in Support of Request for Issuance of Notice of Hearing, pg 3, emphasis in the original) Unlike Respondent's plan, Act 143 would have allowed the insurer to decide whether to impose managed care on unwilling policyholders. Respondent's Preferred Provider Option leaves the choice to the policyholder. In short, contrary to Petitioners' suggestion, PA 143 was more than just a referendum on managed care in no-fault contracts. The rejection of Act 143 does not imply that the Preferred Provider Option is illegal.

The rejection of 1993 PA 143 resulting from the defeat of Proposal C is logically irrelevant to the legality of Respondent's Preferred Provider Option. The question is whether the Preferred Provider Option is inconsistent with the No-Fault Act so that legislative action is necessary before Farmers may offer it. The fact that a very different Act 143 was rejected by the public says nothing useful in answering the question. Petitioners have failed to support their allegation that the Preferred Provider Option is unauthorized and therefore illegal.

Count II

In Count II of the Original Petition, Petitioners argue that the Preferred Provider Option violates the rights of medical providers. More specifically, Petitioners assert that:

> PPOM further utilizes practices which exclude from eligibility a vast majority of chiropractors in this state, contrary to the No-Fault Act's requirement that all reasonably necessary expenses be paid, such that the managed care program which adopts PPOM's criteria for network eligibility excludes chiropractic physicians and re-writes the requirements of the No-Fault Act.

(Original Petition, ¶ 23, pg 13) In response, Respondent provided a copy of PPOM's Directory of Chiropractic Care, which discloses that nearly 200 chiropractors participate in the network. Petitioners dismiss the number of chiropractors in the program as "a smattering" and assert that chiropractors who joined the PPOM network did so before Respondent's Preferred Provider Option began, concluding that Respondent "imposed [the Preferred Provider Option] upon its member physicians." (Memorandum in Support of First Amended Petition, pg 2) Somewhat inconsistently, Petitioners also insist that "The sole issue before the Commissioner on complainant's first two counts of its First Amended Petition revolves solely around whether there is any authority for implementing a managed-care scheme under the No-Fault Act." (*Id.* pg 3)

Petitioners have failed to show probable cause that the Preferred Provider Option violates the rights of medical care providers in general or chiropractors in particular. Policyholders who elect the Preferred Provider Option voluntarily limit their choice of medical care providers to those participating in the PPOM network. Providers who elect to participate in the PPOM network agree to provide their services at rates established by their agreement with PPOM. There is nothing inherently suspect about either of those choices. Under both standard no-fault coverage and the Preferred Provider Option,

policyholders choose their providers. No individual health care provider, regardless of whether he or she participates in the PPOM network, has a right under the No-Fault Act to be paid until an insured chooses that person to provide covered medical care. Policyholders who elect the Preferred Provider Option have simply agreed to limit their choice to PPOM providers.

Petitioners insist that "providers are entitled to be paid for their 'reasonable and customary charge' and the effect of Farmers' program is to force providers such as chiropractors to either accept a rate less than the customary charge or be excluded completely, both of which are contrary to § 3157 and *Munson Medical Center v Auto Club*, 218 Mich App 375 (1996)." (Original Petition, ¶ 24, pg 7) The Commissioner disagrees. Section 3157 of the Insurance Code authorizes providers "lawfully rendering treatment to an injured person" for an accidental injury covered by personal protection insurance to charge a reasonable amount not to exceed the amount the person or institution customarily charges in cases not involving insurance. MCLA 500.3157. It does not confer a right on any particular provider or class of providers to be chosen to provide care. Similarly, in *Munson Medical Center* the Court of Appeals held that a no-fault insurer is required to pay the "customary charges" of health care providers and could not unilaterally limit payments to the amount that a provider routinely accepts in cases covered by Medicare, Medicaid or Blue Cross Blue Shield. That decision did not establish that medical care providers (A) have a right be be selected to provide care under a no-fault policy or (B) could not voluntarily choose to provide care at less than their "customary charge" in exchange for participation in a health care network that may tend to give them access to additional patients.

Petitioners also assert that "[t]his exclusionary practice . . . subjects the policy to

disapproval under §2236 and Chapter 20 for unreasonably and deceptively affecting the risk purportedly assumed." (Original Petition, ¶ 25, pg 6) This allegation is merely conclusory. Petitioners have not presented any authority or separate argument in support of this claim. To the contrary, the underlying theory of the Preferred Provider Option is quite familiar. Health Maintenance Organization subscribers agree generally to limit their choice of providers to those in the network in much the same way that policyholders who elect the Preferred Provider Option agree generally to limit their choice of providers to those in the PPOM network. Petitioners have presented no reason to conclude that the Preferred Provider Option is either unreasonable or deceptive contrary to section 2236.

For these reasons, Petitioners have failed to adequately support their request for a contested case hearing based on the allegations of Count II of the Original Petition.

Count III

Finally, Count III of the Original Petition asserts that Respondent's $500 deductible for persons who elect the Preferred Provider Option but nevertheless choose providers outside the PPOM network, "is not a deductible, but rather is a penalty." They assert that this violates "both public policy and §3109" and "potentially imposes a tremendous hardship on insureds." (Original Petition, ¶ 27, pg 8) Petitioners also assert that there is sufficient question whether there is a " 'reasonable relationship' between the deductible, the reduced premium and the program under either Sec. 3109 or Sec. 3109a" to require a hearing. (Reply in Support of Request for Issuance of Notice of Hearing, pg 3)

The Insurance Division asked Petitioners to provide specific information to support this accusation. On October 25, 2000 the staff addressed the following question to Petitioners:

> Additionally, Petitioners have suggested that there is no reasonable relationship "between the deductible, the reduced premium and the [managed care] program under either Section 3109 or 3109a." Please provide the Commissioner with a complete description of all of the evidence on which Petitioners rely in support of this position, including the names of any witnesses, a description of their expected testimony, and copies of any documents supporting that position.

Petitioners failed to provide any support for their assertion. Instead, Petitioners claimed that the request was "unfair." They claimed that because the Commissioner has exempted insurers from filing no-fault auto policy forms in most cases, they "are in no position to obtain this information." (Memorandum in Support of First Amended Petition, pg 11)

The Insurance Division also asked Respondent for additional information concerning the relationship between the premium reduction and the Preferred Provider Option as follows: "[P]lease describe fully the basis for Farmers' decision to allow a 40% premium reduction for policyholders who elect the managed care option." (October 25, 2000 letter) Farmers responded on November 29, 2000 with the following information:

> In structuring the premiums for the PPO Option, Farmers weighed past and prospective loss experience for policyholders selecting the PPO Option, and past and prospective expenses for providing PIP benefits under the program. In particular, Farmers analyzed the expected savings (and associated costs) from participation in managed care. Three components of the program were reviewed: The anticipated reduction in charges for medical services through use of PPOM's network of health care providers; the expected savings associated with the utilization management services provided by Farmers' designated health care review agency (Sloan's Lake), and the savings to be derived from the "usual, customary, and reasonable" bill review services provided by Sloan's Lake.
>
> Based on experience in Colorado, where Farmers had previously introduced a managed care program, as well as assessments provided by administrators seeking to become Farmers' designated health care review agency (including Sloan's Lake), Farmers estimated that approximately one-quarter of its policyholders would elect the PPO Option in the first year. With respect to that policyholder group, Farmers expected, based on

historical data from Colorado and Sloan's Lake, to realize net cost savings in PIP medical expenses of approximately 25%, representing the difference in cost for providing health care services to PIP claimants within as opposed to outside of the managed care program.

Additional savings were anticipated through the utilization management services to be provided by Sloan's Lake. These services monitor treatment to determine appropriateness, use telephonic medical management, and compare proposed treatment to established guidelines. Farmers anticipated an over all PIP cost reduction from utilization management of 15% of the benefits paid to policyholders selecting the PPO Option.

Finally, additional savings were anticipated from the usual, customary, and reasonable bill review services to be provided by Sloan's Lake.

Under section 2109(1) of the Insurance Code, all rates for automobile insurance "shall not be excessive, inadequate, or unfairly discriminatory." A rate is not "excessive" unless it is unreasonably high for the insurance coverage and "a reasonable degree of competition does not exist for the insurance." MCLA 500.2109(1)(a). A rate is not "inadequate" unless it is "unreasonably low" and its continued use either endangers the solvency of the insurer or will have the effect of destroying competition among insurers. MCLA 500.2109(1)(b). In developing and evaluating rates, due consideration shall be given to a number of varied factors including "past and prospective loss experience within and outside this state, . . . to past and prospective expenses, both countrywide and those specially applicable to this state . . . to underwriting practice and judgment; and to all other relevant factors within and outside this state." MCLA 500.2110. Petitioners have presented no reason to believe that Respondent's premium reduction for the Preferred Provider Option violates these statutory standards. Indeed, Respondent's description of the factors supporting the premium reduction suggests compliance with these standards.

Section 3109 of the No-Fault Act authorizes insurers to offer deductibles not exceeding $300 per accident in exchange for "appropriately reduced premium rates." Other deductible provisions require the approval of the commissioner. MCLA 500.3109(3) On May 31, 2000 the Insurance Division received from Respondent its revised private passenger auto rate filing including the Preferred Provider Option. Respondent defends the $500 deductible on the grounds that a policyholder who elects the Preferred Provider Option but nevertheless seeks medical care outside the PPOM network "significantly increases the risk and cost to Farmers of treating that insured." (Respondent's answer, ¶ 27, pg 15) Petitioners recognize that fees for care within the network are generally less than a provider's customary charge. (Original Petition, ¶ 24, pg 7) Because treatment outside the network is more expensive and a policyholder who elects the Preferred Provider Option receives a substantial premium discount for agreeing to treat within the PPOM network, there is no basis for objecting to the deductible. A policyholder may avoid it by fulfilling his or her commitment to rely on PPOM providers.

This would be a different case if Respondent were artificially reducing the cost of the Preferred Provider Option and thereby unfairly shifting the cost of providing benefits to those who elect the standard fee for service no-fault coverage. Persons who elect the fee for service coverage should not be required to subsidize the Preferred Provider Option as a way of forcing policyholders out of the fee for service coverage and into the Preferred Provider Option. In the instant case, there is no evidence that the Preferred Provider Option premium discount is not reasonably calculated to reflect the reduced costs and expenses expected from the program.

Finally, Petitioners' reliance on section 3109a is misplaced. Section 3109a requires insurers to offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. MCLA 500.3109a. As required by that section, Respondent offers an Other Insurance Rate Credit, which discounts the PIP premium by up to 35% if a policyholder agrees to make his no-fault coverage secondary to other insurance. However, Respondent does not offer the other insurance credit in combination with the Preferred Provider Option, so section 3109a does not apply in the context of the Preferred Provider Option. (Respondent's November 29, 2000 letter; see also Exhibit A to the Original Petition)

Under the circumstances, Petitioners have failed to show probable cause that the Preferred Provider Option violates the Insurance Code as alleged in Court III.

IV
ORDER

Therefore, it is ORDERED that:

1. Petitioners' "Request for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated August 10, 2000 is denied.

2. Petitioners' "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated November 22, 2000 is denied on the grounds stated in Counts I, II, and III.

3. Respondent shall answer Court IV of Petitioners' "First Amended Petition for Issuance of Notice of Hearing and Commencement of Administrative Proceedings" dated November 22, 2000 within 30 days from the date of this order pursuant to AACS 1983, R. 500.2104(1)(b).

Frank M. Fitzgerald
Commissioner
Office of Financial and Insurance Services

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

MICHIGAN CHIROPRACTIC COUNCIL and the MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners,

v

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, FARMERS INSURANCE EXCHANGE and MID-CENTURY EXCHANGE COMPANY,

Respondents.
_____/

OPINION AND ORDER

File No. 01-93481-AA

At a session of said Court held in the City of Lansing, Ingham County, Michigan, on the 17th day of April, 2002, the Hon. Thomas L. Brown presiding.

This matter is before the Court on Petitioners' Petition for Review of Respondent Commissioner's final decisions dated January 23, 2001, and March 21, 2001. Oral argument was heard on November 29, 2001, at which time the appeal was taken under advisement. Pursuant to this Court's Order dated December 11, 2001, the Court accepted for filing an Amicus Curiae Brief from the Michigan State Medical Society, as well as an Amicus Statement for Support from the Michigan Brain Injury Providers Council. Having fully reviewed this matter, the Court makes the following determinations.

The case file reflects that on August 10, 2000, a complaint and hearing request was filed with Respondent Commissioner wherein Petitioners sought to have withdrawn the Commissioner's July

1, 2000 approval of Respondent Farmers' Preferred Provider Organization (PPO) Option Endorsement (hereinafter Option). According to a Media Relations announcement released by Farmers (*See* Petitioners' Exhibit B), the Option offers "consumers access to a lower cost managed care option for personal injury protection (PIP) that will result in a 40% savings annually in the PIP portion of their coverage." The announcement further stated that "current and future policyholders [will have] the option of selecting a new PIP plan that directs policyholders to seek care from providers within the [Preferred Providers of Michigan] PPOM network . . . ." Farmers selected PPOM as the exclusive provider network for its policyholders.

Petitioners complained, however, that the Option violated the No-Fault Act of Michigan's Insurance Code, MCL 500.100 *et seq*; MSA 24.12001 *et seq*, and violated the rights of insureds and medical care providers. Farmers submitted a response to the complaint, and Petitioners replied. On January 23, 2001, the Commissioner issued a decision denying Petitioners' complaint and request, as well as denying Counts I, II, and III of Petitioner's First Amended Petition. Additionally, the Commissioner's March 21, 2001 decision denied, without prejudice, Count IV of Petitioner's Amended Petition after determining that the questions of law involved therein were currently pending before the Court of Appeals in *Sprague v Farmers Insurance Exchange* (No. 227400). As a result of the respective decisions, Petitioners filed the instant appeal on April 19, 2001.

Pursuant to MCL 500.244(1); MSA 24.1244(1): "A person aggrieved by a final order, decision, finding, ruling, opinion, rule, action, or inaction provided under this act may seek judicial review in the manner provided for in chapter 6 of the administrative procedures act of 1969 . . . ." Where "no contested hearing [is] required or held, the proper standard of review [is] that set out in Const 1963, art 6, § 28 . . . ." *Northwestern Nat'l Cas Co v Ins Comm'r*, 231 Mich App 483, 490; 586 NW2d 563 (1998). Consequently, "it is not proper for the circuit court . . . to review the

evidentiary support of an administrative agency's determination . . . . In such cases, '[j]udicial review is not de novo and is limited in scope to a determination whether the action of the agency was authorized by law.'" *Id.* at 488 (quoting *Brandon School Dist v Michigan Educ Special Services Ass'n*, 191 Mich App 257, 263; 477 NW2d 138 (1991) (emphasis omitted)).

The focus of this appeal is on Michigan's No-Fault Act, MCL 500.3101 *et seq*; MSA 24.13101 *et seq*. According to *Shavers v Attorney General*, 402 Mich 554, 578-79; 267 NW2d 72 (1978), cert den 442 US 934 (1979):

> The [No-Fault Act], which became law on October 1, 1973, was offered as an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system. The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses. The Legislature believed this goal could be most effectively achieved through a system of compulsory insurance, whereby every Michigan motorist would be required to purchase no-fault insurance or be unable to operate a motor vehicle legally in this state. Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort.

"The no-fault insurance act is remedial in nature and must be liberally construed in favor of persons intended to benefit thereby." *Gobler v Auto-Owners Ins Co*, 428 Mich 51, 61; 404 NW2d 199 (1987). *See also Maloney ex rel Gauntlett v Auto-Owners Ins*, 242 Mich App 172, 179; 617 NW2d 735 (2000). According to *Rohlman v Hawkeye Sec Ins Co*, 442 Mich 520; 502 NW2d 310 (1993), "PIP benefits are mandated by statute under the no-fault act, . . . and, therefore, the statute is the 'rule book' for deciding the issues involved in questions regarding awarding those benefits." *Id.* at 524-25. *See also Cruz v State Farm Mut Auto Ins Co*, 241 Mich App 159, 164; 614 NW2d 689 (2000).

The crux of Petitioners' appeal is whether an insurer may establish a conflicting mechanism in its payment-of-no-fault-benefits policy where the Act already prescribes the mechanism to be followed. Petitioners contend that Farmers' Preferred Provider Option violates the No-Fault Act because the creation of a no-fault managed care system is not authorize by law. Rather, the No-Fault Act is a fee-for-service arrangement. Petitioners cite for support of this proposition to the applicable provisions of the Insurance Code; notably Sections 3107 and 3109. Petitioners also argue that authority for the managed-care system is nonexistent because 1993 Public Act (PA) 143 was rejected by a referendum vote of Michigan's citizen on November 8, 1994.

Petitioners cite to *People v Price*, 124 Mich App 717; 335 NW2d 134 (1983), and *English v Saginaw County Treasurer*, 81 Mich App 626; 265 NW2d 775 (1978), for the proposition that legislative amendments are presumed to change the state of the existing law and that no such change can be presumed to be without purpose. Reliance is also placed on *DAIIE v Higginbotham*, 95 Mich App 213, 221; 290 NW2d 414 (1980) (stating that "[w]here an insurance policy contains an exclusionary clause that was not contemplated by the Legislature, that clause is invalid and unenforceable.").

Petitioners also cite to *In re Proposals D & H*, 417 Mich 409, 423; 339 NW2d 848 (1983), which states: "The political foundation for initiative and referendum is the assumption that a free people act rationally in the exercise of their power." Further, "[t]he people are presumed to know what they want, to have understood the proposition submitted to them in all of its implications, and by their approval vote to have determined that this [proposal] is for the public good and expresses the free opinion of a sovereign people." *Id.* (quotations and citation omitted).

Petitioners maintain that when 1993 PA 143 was repealed it, in effect, amended the No-Fault Act and thereby removed the provisions which permitted managed care. Consequently, the rejection

of Sections 3104a and 3104b, as well as the amendment to Section 3107, left managed-care systems unlawful. Thus, statutory authority for a managed-care system never came into being. *See Hofmann v Auto Club Ins Ass n*, 211 Mich App 55; 535 NW2d 529 (1995). *See also English, supra.*

Respondents disagree with Petitioners' assertions, however, and contend that the true question involved in this appeal is whether the Commissioner had the authority to deny Petitioners' request for a contested-case hearing. Having fully considered the authority cited by the parties in this matter, the Court does not agree with Respondents' contention. Instead, the Court first turns to Respondent Commissioner's response to Petitioners' claims.

Respondent states that Farmers' Option is not illegal on grounds that it is unauthorized. Nor is it inconsistent with the requirements that no-fault coverage provide all reasonable charges for necessary treatment. Further, that the Option is not illegal on the ground that the rejection of 1993 PA 143 outlawed managed care in no-fault policies. Respondent relies on the January 23, 2001 decision, which states as follows:

> [I]t is mere speculation to conclude that the rejection of 1993 PA 143 was a rejection of the concept of "clinical care management." It could just as easily be argued that the public rejected trading permanent loss of unlimited personal injury protection benefits for a transitory rate reduction.
>
> Moreover, Farmers' Preferred Provider Option is different that Act 143 in another critical aspect. Proposed section 3104b in Act 143 would have allowed no-fault insurers to impose "clinical care management" upon unwilling policyholders. But Farmers' Preferred Provider endorsement is optional. Policyholders may elect to stay with the existing fee for service arrangement. There is a significant difference between allowing *policyholders to elect* managed care and authorizing *insurers to impose* it on unwilling policyholders . . . . Unlike [Farmers'] plan, Act 143 would have allowed the insurer to decide whether to impose managed care on unwilling policyholders. [The Option] leaves the choice to the policyholder . . . .

> The rejection of 1993 PA 143 resulting from the defeat of Proposal C is logically irrelevant to the legality of [the] Option. The question is whether the . . . Option is inconsistent with the No-Fault Act so that legislative action is necessary before Farmers may offer it. The fact that a very different Act 143 was rejected by the public says nothing useful in answering the question. Petitioners have failed to support their allegation that the . . . Option is unauthorized and therefore illegal. (Emphasis supplied).

As to Farmers' response to Petitioners' arguments, it agrees with the Commissioner that the decisions properly determined that the Option *does not* impose managed care on any insured, that it is consistent with the intent and purpose of the No-Fault Act, and that it is not prohibited by the Act. Moreover, Farmers takes issue with the applicability of cases such as *Rohlman, supra*, and *Cruz, supra*, to the instant appeal. Instead, Farmers relies on *Morgan v Citizens Ins Co*, 432 Mich 640; 442 NW2d 626 (1989), and *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 56; 457 NW2d 637 (1990), to support its argument that the Commissioner's decisions were proper and authorized by law.

Having fully reviewed the parties' respective briefs and supporting case law, as well as the Amicus brief and statement in support, the Court is persuaded by Petitioners' argument that Farmers' Option illegally adds an additional requirement that health care providers must be members of Farmers' exclusive Preferred Provider network. The Court agrees with Petitioners that this requisite conflicts with the Act's requirement that health care providers be reimbursed when providing treatment for a covered injury. Moreover, Petitioners have convinced the Court that chiropractors who wish to participate in the no-fault system for Farmers' insureds are forced to accept a fee which is less than the customary and reasonable fee required by the Act.

The Court also agrees with Petitioners' remaining arguments as outlined in their brief on appeal, and as represented during oral argument. As stated by Petitioners, the authority to bring

managed care to the no-fault system is a matter which the Legislature must determine. The Court applies this sound statement to the instant situation. Respondents' arguments to the contrary do not persuade the Court to reach a different conclusion. Accordingly, the Court is of the opinion that the Option at issue is not authorized by law.

IT IS ORDERED, therefore, that Respondent Commissioner's decisions dated January 23, 2001, and March 21, 2001, are **REVERSED**.

Hon. Thomas L. Brown
Circuit Judge

PROOF OF SERVICE

I do hereby certify and return that I served a copy of the above order upon Petitioners and Respondents by placing said order in a sealed envelope addressed to each with full postage prepaid thereon and placing said envelope in the United States Mail at Lansing, Michigan, on April 30, 2002.

Michael G. Lewycky
Court Officer

A TRUE COPY
CLERK OF THE COURT

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL DISTRICT
INGHAM COUNTY

MICHIGAN CHIROPRACTIC COUNCIL and the MICHIGAN CHIROPRACTIC SOCIETY,

Plaintiffs,

v

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY

Defendant.

Case No. 01-93481-AA

HON. THOMAS L. BROWN

A.G. No. 2001007731A

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Attorney for Respondents Farmers Insurance Exchange and Mid-Century Insurance Company

ORDER AMENDING OPINION AND ORDER

At a session of said Court, held in the Ingham County Circuit Court 313 W. Kalamazoo, Michigan on May 22, 2002.

HONORABLE THOMAS L. BROWN, CIRCUIT JUDGE

Respondents having filed motions to amend and clarify this Court's April 30, 2002 Opinion and Order in this matter and Petitioners having filed no response in opposition,

Now therefore, Respondents' motions to amend and clarify are hereby granted as follows:

1. The Court's decision on Counts I and II of the Petition for Review, reversing Respondent Commissioner's January 23, 2001, Order regarding Farmers' Preferred Provider Organization (PPO) Option Endorsement, is hereby restated and incorporated herein by reference as the Court's final Order as to those counts.

2. The Court's April 30, 2002 decision on Count III of the Petition for Review, dealing with Respondent Commissioner's March 21, 2001, Order, is hereby modified. In light of the issuance by the Court of Appeals of its May 10, 2002, Opinion in the case of *Sprague v Farmers Insurance Exchange* (No. 227400), Count III of the Petition for Review is hereby dismissed as moot.

3. In all other respects, the attached Opinion and Order is restated and incorporated as if fully set forth herein. This resolves the last pending claim and closes this case.

Thomas L. Brown, Circuit Judge

Consent to Entry:

By _____
Kevin J. Moody (P34900)
Attorney for Petitioners

By _____
William A. Chinnowth (P27622)
Attorney for Respondent Commissioner
of Financial and Insurance Services

By _____
Peter L. Gratsos (P24621)
Attorney for Respondents Farmers
Insurance Exchange and Mid-Century
Insurance Company

Now therefore, Respondents' motions to amend and clarify are hereby granted as follows:

1. The Court's decision on Counts I and II of the Petition for Review, reversing Respondent Commissioner's January 23, 2001, Order regarding Farmers' Preferred Provider Organization (PPO) Option Endorsement, is hereby restated and incorporated herein by reference as the Court's final Order as to those counts.

2. The Court's April 30, 2002 decision on Count III of the Petition for Review, dealing with Respondent Commissioner's March 21, 2001, Order, is hereby modified. In light of the issuance by the Court of Appeals of its May 10, 2002, Opinion in the case of *Sprague v Farmers Insurance Exchange* (No. 227400), Count III of the Petition for Review is hereby dismissed as moot.

3. In all other respects, the attached Opinion and Order is restated and incorporated as if fully set forth herein. This resolves the last pending claim and closes this case.

THOMAS L. BROWN

Thomas L. Brown, Circuit Judge

Consent to Entry:

By _____
Kevin J. Moody (P34900)
Attorney for Petitioners

By _____
William A. Chenoweth (P27622)
Attorney for Respondent Commissioner
of Financial and Insurance Services

By _____
Peter L. Gustafson (P24621)
Attorney for Respondents Farmers
Insurance Exchange and Mid-Century
Insurance Company

A TRUE COPY
CLERK OF THE COURT
30th JUDICIAL CIRCUIT COURT

3

STATE OF MICHIGAN

COURT OF APPEALS

MICHIGAN CHIROPRACTIC COUNCIL,
MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners-Appellees,

v

COMMISSIONER OF THE OFFICE OF
FINANCIAL AND INSURANCE SERVICE,

Respondent-Appellant,

and

FARMERS INSURANCE EXCHANGE, and
MID-CENTURY INSURANCE COMPANY,

Intervenors-Respondents.

FOR PUBLICATION
June 1, 2004
9:15 a.m.

No. 241870
Ingham Circuit Court
LC No. 01-093481-AA

MICHIGAN CHIROPRACTIC COUNCIL,
MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners-Appellees,

v

COMMISSIONER OF THE OFFICE OF
FINANCIAL AND INSURANCE SERVICE,

Respondent,

and

FARMERS INSURANCE EXCHANGE, and
MID-CENTURY INSURANCE COMPANY,

Intervenors-Respondents-Appellants.

No. 241874
Ingham Circuit Court
LC No. 01-093481-AA

Before: Fitzgerald, P.J., and Neff and White, JJ.

NEFF, J.

In these consolidated appeals, respondent Commissioner of the Office of Financial and Insurance Services, and intervenors-respondents Farmers Insurance Exchange and Mid Century Insurance Company ("Farmers") appeal by leave granted an order of the circuit court that reversed the commissioner's denial of petitioners' challenge to a preferred provider organization (PPO) option offered under Farmers' no fault automobile insurance policies. The circuit court concluded that Farmers' PPO option violated the no-fault statute, MCL 500.3101 *et seq.*, by illegally adding an additional requirement that health care providers be members of Farmers' exclusive Preferred Providers of Michigan (PPOM) network. We affirm.

I

This case presents an issue of first impression. The essential question is whether Farmers' implementation of a PPO endorsement option under Michigan no-fault automobile insurance, by which policyholders receive a reduction in their personal injury protection (PIP) premium in exchange for agreeing to obtain medical treatment exclusively from providers in Farmers' PPO network, violates Michigan's no-fault insurance statute. We concur with the circuit court's conclusion that the PPO endorsement inherently conflicts with Michigan's no fault insurance scheme, which was enacted as a fee-for-service system with regard to medical benefits. We therefore find no error in the circuit court's reversal of the Commissioner's decision to permit Farmers' no-fault PPO endorsement.

II

The parties disagree on the standard of review. Their dispute is essentially resolved by this Court's explication of the standard of review applicable to a decision of the commissioner that is not based on an evidentiary hearing, i.e., that is not a contested case. *Northwestern Nat'l Cas Co v Comm'r of Ins*, 231 Mich App 483, 487-491; 586 NW2d 563 (1998); see also LeDuc, Michigan Administrative Law, § 8:08, p 564, § 9:02, p 601, § 9:05, pp 608-609. Judicial review in this instance is limited in scope to whether the action of the agency was "authorized by law." *Northwestern Nat'l Cas, supra* at 488. An agency's decision is not authorized by law if it is in violation of statute or constitution, in excess of the statutory authority or jurisdiction of the agency, made upon unlawful procedures resulting in material prejudice, or is arbitrary and capricious. *Id.*

Where the question at issue is whether an agency decision is in violation of statute or constitution, the question is one of law to be decided by the courts, and the principles of statutory construction are relevant. LeDuc, § 9:19, p 636. The courts generally accord deference to an agency's interpretation of a statute in view of the agency's substantial expertise and unique role in regard to the statute at issue unless that interpretation is clearly wrong. *Id.* at 636-638; *Taylor v Second Injury Fund*, 234 Mich App 1, 13; 592 NW2d 103 (1999); see also *Consumers Power Co v Public Service Comm*, 460 Mich 148, 173-175; 596 NW2d 126 (1999) (Brickley, J., dissenting) (noting the varying deference accorded agency interpretation of statutes).

Nonetheless, an administrative interpretation is not binding on the courts and must be rejected if not in accord with the intent of the Legislature. *Lanzo Const Co, Inc v Dep't of Labor*, 86 Mich App 408, 414; 272 NW2d 662 (1978). "[D]eference is given to an administrative agency's decisions, provided that the agency's construction is consistent with the purpose and policies of the statute itself." *Empire Iron Mining Partnership v Orhanen*, 455 Mich 410, 416; 565 NW2d 844 (1997).

III

This case has its genesis in the commissioner's tacit approval of Farmers' PPO option policy as a new no-fault insurance product in Michigan effective in July 2000 pursuant to MCL 500.2236. The Legislature granted the commissioner the power to approve insurance forms before they are used. *American Community Mut Ins Co v Comm'r of Ins*, 195 Mich App 351, 357; 491 NW2d 597 (1992). Under MCL 500.2236(1), the commissioner has a duty to determine that all the statutory requirements of the no-fault act are complied with in insurance policies. *Cruz v State Farm Mut Automobile Ins Co*, 466 Mich 588, 599 n 15; 648 NW2d 591 (2002).

MCL 500.2236 provides in relevant part: [1]

> A basic insurance policy form ... shall not be issued or delivered to any person in this state, and an insurance ... application form if a written application is required and is to be made a part of the policy or contract, a printed rider or indorsement form or form of renewal certificate, and a group certificate in connection with the policy or contract, shall not be issued or delivered to a person in this state, until a copy of the form is filed with the insurance bureau and approved by the commissioner as conforming with the requirements of this act and not inconsistent with the law. Failure of the commissioner to act within 30 days after submittal constitutes approval.... [MCL 500.2236(1).]

The statute requires form approval by the commissioner to protect the public from clauses that mislead, deceive, or unreasonably deny coverage. *American Community Mut Ins, supra* at 358; *Progressive Mutual Ins Co v Taylor*, 35 Mich App 633, 642; 193 NW2d 54 (1971). In this case, the commissioner did not act on the policy form submitted by Farmers and consequently Farmers' new PPO option was automatically approved after thirty days. MCL 500.2236(1).

---

[1] Minor changes in § 2236 were effected by 2002 PA 664, but do not bear on the analysis in this case.

In August 2000, petitioners filed a request for issuance of a notice of hearing and commencement of administrative proceedings with the commissioner pursuant to MCL 500.2029 and MCL 500.2236. Petitioners alleged that Farmers' offer or imposition of a managed care[2] network under the no-fault act was unlawful because there is no authority under the act for implementing a managed care scheme. Petitioners sought commencement of a Chapter 20[3] proceeding against Farmers for unfair, deceptive, and misleading trade practices pursuant to § 2029 and issuance of a notice of disapproval by the commissioner pursuant to § 2236.

Under the insurance code, the commissioner has the power, upon probable cause, to investigate the affairs of a person engaged in the insurance business in Michigan.[4] MCL 500.2028. Pursuant to MCL 500.2029, the commissioner may conduct a hearing when there is probable cause to believe that an insurer is engaged in unfair or deceptive practices:

> When the commissioner has probable cause to believe that a person engaged in the business of insurance has been engaged or is engaging in this state in an unfair method of competition, or an unfair or deceptive act or practice in the conduct of his business, as prohibited by sections 2001 to 2050, [MCL 500.2001 to MCL 500.2050] and that a hearing by the commissioner in respect thereto would be in the interest of the public, he shall first give notice in writing ... to the person involved, setting forth the general nature of the complaint against him and the proceedings contemplated pursuant to sections 2001 to 2050....

MCL 500.2236(5) provides for the commissioner's withdrawal of approval of an insurance form:

> Upon written notice to the insurer, the commissioner may disapprove, withdraw approval or prohibit the issuance, advertising, or delivery of any form to any person in this state if it violates any provisions of this act, or contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and

---

[2] "Managed care encompasses a variety of health-care delivery forms including HMOs, PPOs, individual practice associations, as well as other prepaid health plans." Gilchrist, *Managed care takes to the highway: implication for insureds*, 29 JLMEDETH 203, 207 (2001). Managed care represents a shift from the traditional fee-for-service payment arrangements for health-care costs. *Id.* at 203, 206. According to the Gilchrist article, four state legislatures and one commissioner of insurance (Massachusetts) had to date authorized insurance companies to offer consumers a managed care option in automobile insurance policies. *Id.* at 203-205.

[3] Chapter 20 provides recourse for unfair and prohibited trade practices and frauds.

[4] MCL 500.2028 provides: "Upon probable cause, the commissioner shall have power to examine and investigate into the affairs of a person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 2001 to 2050 [MCL 500.2001 to MCL 500.2050]."

> conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy....

The commissioner denied petitioners' request for a contested hearing, finding that they had failed to show probable cause to support their request. The commissioner also concluded that Farmers' PPO option did not violate the insurance code.

Petitioners sought review of the commissioner's decision in the circuit court. Following a hearing, the court reversed the commissioner's decision, finding that Farmers' PPO option is not authorized by law. The court agreed with petitioners that the authority to incorporate managed care into the no-fault system is a matter for the Legislature to decide. We concur in these conclusions and affirm the decision of the circuit court on that basis.

IV

The no-fault act[5] was enacted by the Legislature in 1972 as a comprehensive scheme of compensation designed to provide sure and speedy recovery of certain economic losses resulting from motor vehicle accidents. *Spencer v Citizens Ins Co*, 239 Mich App 291, 300; 608 NW2d 113 (2000). The act radically redefined the nature of Michigan's motor vehicle insurance. *Cruz, supra* at 595-596; *Shavers v Kelley*, 402 Mich 554, 590; 267 NW2d 72 (1978).

> The Michigan No-Fault Insurance Act, which became law on October 1, 1973, was offered as an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system. The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses. The Legislature believed this goal could be most effectively achieved through a system of *compulsory* insurance, whereby every Michigan motorist would be required to purchase no-fault insurance or be unable to operate a motor vehicle legally in this state. Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort. [*Id.* at 578-579.]

Under the no-fault act, PIP insurance is based on a comprehensive and expeditious benefit system. *Id.* at 579.

In general, personal injury protection insurance under the act provides:

> (a) all medical costs and expenses occasioned by injuries sustained in a motor vehicle accident, including expenses for rehabilitation .... [*Id.* at 620, citing § 3107.]

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[5] 1972 PA 294.

Despite their comprehensive nature, the statutory provisions mandating medical benefits are brief and concise. Section 3105 of the act provides that, subject to the other provisions of the act, "an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle...." MCL 500.3105(1); *Sprague v Farmers Ins Exch*, 251 Mich App 260, 266; 650 NW2d 374 (2002). The specific requirements for medical benefits are governed by MCL 500.3107 and MCL 500.3157. Subsection 3107(1)(a) sets forth the type of benefits a no-fault insurer is liable for under § 3105. Section 3157 details the allowable provider charges. *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365, 373-374; 670 NW2d 569 (2003).

MCL 500.3107 provides in pertinent part:

> (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:
>
> (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

MCL 500.3157 provides:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

It is undisputed that the no-fault act is silent on the issue of managed care medical benefits. The parties take opposing positions on the legal implication of this lack of an explicit pronouncement on managed care by the Legislature. Petitioners argue that there is no statutory authority for the PPO endorsement and it is therefore illegal. Farmers argues that the no-fault act does not proscribe a PPO option and therefore it does not violate the statute because it meets the statutory requirements for no-fault medical benefits, i.e., reimbursement of all reasonable charges for reasonably necessary products, services, and accommodations, MCL 500.3107.

The no-fault act's silence with regard to a particular matter does not necessarily preclude its use. *Cruz, supra* at 598. An insurer's provision that facilitates the goals of the act and is harmonious with the Legislature's no-fault insurance regime is valid. *Id.* Conversely, a provision that is not in harmony with the no-fault scheme established by Legislature must be rejected. *Id.*

A

The PPO endorsement to Farmers' no-fault insurance policies states:

> (c) Preferred Provider Option Endorsement—
>
> Policyholders who elect the Preferred Provider Endorsement will receive a 40% reduction on their PIP rate. The endorsement requires the insured to choose a physician from our captured network, Preferred Providers of Michigan, to manage health care in the event of a covered injury.
>
> The E7143 will not be allowed if the option is selected. The other insurance credit will not be allowed if this option is selected.
>
> All policies in the household are required to carry the PPO option if the insured selects this option. Disclosure form 51-0693 must be signed by the insured for each policy in the household to verify selection of the PPO option.

The E7143 referenced in the PPO option is a PIP rate reduction offered for a $300 deductible:[6]

> (a) $300 Deductible P.I.P. (E-7143)—
>
> Policyholders who elect to take the "Endorsement Establishing Deductible and Waiting Period" will receive a 15% reduction from the P.I.P. rates. The endorsement provides a $300 medical deductible and a 7 day waiting period on benefits for "work loss". (Not available if the other insurance rate credit is taken.)

The "other insurance credit" referenced in the PPO option states:[7]

> (b) Other Insurance Rate Credit—
>
> P.I.P. rates are discounted 25% if the insured elects their [sic] P.I.P. coverage to be secondary over other A & H medical insurance or another 10% if he elects his weekly indemnity coverage to be secondary to other wage continuation coverage. Thirty Five percent (35%) will be deducted if both coverages are secondary.
>
> These credits are applied to the reduced rate after other credits such as second car discount, etc., have been applied.
>
> If this option is selected, the $300 deductible credit under the E-7143 described in (a) above will not be allowed.

---

[6] Under subsection 3109(3) of the no-fault act, "[a]n insurer providing personal protection insurance benefits may offer, at appropriately reduced premium rates, a deductible of a specified dollar amount which does not exceed $300.00 per accident."

[7] The "other insurance credit" is presumably offered pursuant to § 3109a, the no-fault act's coordination of benefits provision. *Sprague, supra* at 267.

Thus, under Farmers' policies, if a policyholder elects the PPO option, the policyholder forfeits other PIP premium deductions. This "exchange system" of premium discounts renders illusory the touted reduction in the cost of insurance to policyholders. The question arises whether consumers, who are prone to overlook the detail of their insurance policies, will be lured to accept the PPO option on the basis of the well-publicized forty-percent reduction in their PIP rate, when in fact many will lose significant, and perhaps comparable, premium discounts for the other insurance option or the E-7143, already in place, but which no longer apply. This system certainly has the potential for deception—misleading consumers and the public in general. This potential deception provides further basis for reversing the commissioner's decision pursuant to MCL 500.2029, on the basis of unfair, deceptive, and misleading trade practices.

B

Farmers imposes penalties if a policyholder selects the PPO option, but subsequently goes out of network:

> [I]f a policyholder elects to go out of network for care, they [sic] will be required to pay:
>
> - a $500 deductible (which is not applicable to those who stay in network for care)
> - any charges by the provider beyond which would have been reimbursed according to the carriers' usual and customary fee schedule.

While the Michigan Supreme Court has sanctioned managed care under the no-fault act, this sanction relates only to managed care under health care plans, which only come into play under the no-fault statutory provisions for coordinated benefits, MCL 500.3109a.[8] *Tousignant v Allstate Ins Co*, 444 Mich 301; 506 NW2d 844 (1993). Section 3109a requires insurers to offer reduced premiums for coordinating no-fault benefits with health and accident coverage. *Sprague, supra* at 267.

In *Tousignant*, the Supreme Court held that a no-fault insurer is not liable for medical expenses that the insured's coordinated health care insurer is contractually required to pay for or provide.[9] *Tousignant, supra* at 303. The Court reasoned that the legislative purpose underlying § 3109a was one of avoiding duplicative payment, which required that an insured who chooses to coordinate coverage must obtain payment and services from the health insurer to the extent of the health coverage available. *Id.* at 306-308.

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[8] Effective June 3, 1974, the Legislature amended the no-fault act by adding § 3109a. 1974 PA 72; *Porter v Michigan Mut Liability Co*, 80 Mich App 145, 150 n 6; 263 NW2d 318 (1977)

[9] *Tousignant* did not address issues that might arise where a health insurer fails to pay or reimburse an insured for an expense, or in the case of a health insurer who is also a provider, fails to provide medical care. *Tousignant, supra* at 303, n 1.

Under § 3109a, insurers are required to offer benefits coordination with health and accident coverage at appropriately reduced automobile insurance premium rates. *Tousignant, supra* at 304, 307; *Sprague, supra* at 267-268. Coordination is optional. *Tousignant, supra* at 307. Insureds who coordinate are deemed to have made the health insurer the "primary" insurer with respect to automobile accident injuries. *Id.* However, a no-fault insured who desires duplicative medical coverage from no-fault and health insurers can forego the premium reduction for coordination and thus contract for dual coverage. *Id.*

In *Tousignant*, the no-fault claimant had coordinated coverage under a managed care health maintenance organization (HMO) provided through her employer, which as the PPO in this case, required that treatment be obtained from designated physicians or facilities. *Id.* at 304-305, 309. The Court recognized that a no-fault insured generally has a wide choice of physicians and facilities. *Id.* at 309. The Court noted, however, that § 3109a did not require that "other health coverage" with which the insured chose to coordinate, provide such a choice. *Id.* at 309. Further, "the legislative policy embodied in § 3107, requiring a no-fault insurer to provide necessary medical expense, [did not] require that 'other health coverage' under § 3109a provide the no-fault insured with a choice of physician or facility." *Id.* at 309-310.

Managed care under the coordinated health and accident coverage of § 3109a is clearly distinguishable in concept from the general no-fault medical benefits under subsection 3107(1)(a), as are the legislative purposes underlying these provisions. General no-fault benefits under subsection 3107(1)(a) offer a range of choice. Managed care, under a PPO plan, offers only limited choice. The substitution of a PPO plan for no-fault general medical benefits is therefore not in keeping with the no-fault act.

Although our courts have sanctioned managed care under § 3109a health care plans, where the managed care does not meet the broader requirements of § 3107, an insurer remains liable for all reasonably necessary services pursuant to § 3107. Recently, in *Sprague, supra*, this Court held that where HMO coordinated coverage under § 3109a excluded coverage for chiropractic services, the no-fault insurer was liable for the chiropractic expenses to the extent the plaintiff could show that they represent reasonable charges incurred for reasonably necessary services, subsection 3107(1)(a). *Id.* at 265, 270-271.

A similar result has been reached where other statutory mandates restrict access to the benefits in § 3107. In enacting the no-fault scheme, the Legislature provided for a set-off of government benefits that duplicate no-fault benefits, subsection 3109(1), to reduce and contain the cost of basic insurance. MCL 500.3109(1); *Morgan v Citizens Ins Co of America*, 432 Mich 640, 648; 442 NW2d 626 (1989). Where government benefits under subsection 3109(1) fall short of the § 3107 requirement of "reasonably necessary" services, because of differences in quality and service, the requirements of § 3107 apply. *Id.* at 643, 648. The *Morgan* Court held that the no-fault claimant could be entitled to treatment at nonmilitary hospital because subsection 3109(1) does not mandate the offset of all governmentally provided benefits, only duplicative benefits:

> The no-fault act preserves to injured persons a reasonable choice of hospitals and physicians although this may add to the premium cost of no-fault insurance. The no-fault insurer cannot, in the name of reducing the premium cost, require an injured person to obtain medical service from a particular provider. [*Id.* at 647-648.][10]

The fact that the Legislature expressly provided for reduced premiums in § 3109a with regard to coordinated health-care benefits, and also provided for the offset of duplicative government benefits and reduced premium rates for deductibles under § 3109, further supports a conclusion that the Legislature did not intend premium reductions with regard to benefit limitation options under § 3107. Under the rules of statutory construction, provisions of a statute must be read in the context of the entire statute so as to produce an harmonious and consistent whole. *Cherry Growers, Inc v Michigan Processing Apple Growers, Inc*, 240 Mich App 153, 170; 610 NW2d 613 (2000). "The omission of a provision in one part of a statute, which is included elsewhere in the statute, should be construed as intentional. *Id.*

"The most striking feature of Michigan's no-fault system is that, apparently alone among the no-fault states, it provides unlimited lifetime medical and rehabilitation benefits." House Legislative Analysis, HB 4156, July 29, 1993, p 1. "The no-fault act preserves to the injured person a choice of medical service providers." *Morgan, supra* at 643; see also *Tousignant, supra* at 309. On the contrary, inherent in the concept of managed care is limited choice.

Michigan's no-fault insurance system has at its core the premise—and the promise, of wideranging medical benefits from the available spectrum of providers, in exchange for which the driving public accepts the statutorily-prescribed, limited redress for personal injuries suffered. Farmers' PPO endorsement strikes a new and entirely different bargain with policyholders, one for which there are no legislative prescriptions. The fact that, absent such prescriptions, Farmers' has modeled its offered option after the statutory prescriptions for reduced premiums for optional coordinated health care, § 3109a,[11] while laudable, is nonetheless essential proof that premium reductions for limited no-fault medical benefits under § 3107 were not within the Legislature's intent in enacting the no-fault act. Where the Legislature contemplated limitations on § 3107 benefits, associated statutory requirements are provided in the act, not left to the insurers' devise.

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[10] The Court noted that its holding was limited to coordination of governmental benefits and that it expressed no opinion concerning the situation where a claimant's health insurance was primary pursuant to § 3109a. *Morgan, supra* at 647 n 9.

[11] Section 3109a provides that an insurer shall offer premium reductions for coordinated health coverage and that the deductibles and exclusions required to be offered shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household. Farmers' PPO endorsement provides that policyholders who elect the endorsement will receive a forty percent reduction on their PIP rate and that all policies in the household are required to carry the PPO option.

Further, Farmers' PPO option carries with it severe penalty provisions, imposed when a no-fault claimant acquires out-of-network services despite the policyholder's agreement to the PPO endorsement. These penalties clash with no-fault precepts, and further convince us that the endorsement must be rejected as inharmonious with the no-fault regime established by the Legislature. *Cruz, supra* at 595-596, 598.

Managed care, and in particular, the PPO option at issue, fundamentally alters the essential premise of Michigan no-fault insurance and is inconsistent with the no-fault act general benefit provisions. Incorporating managed care into the no-fault scheme, however beneficial or desirable from a policy standpoint, cannot emanate from the innovations of insurance companies or the courts, but only from the Legislature itself.[12]

Managed care, in the form of a limited provider network, clearly was not contemplated in the no-fault range of choice system for medical benefits prescribed under § 3107. Farmers' system of PPO-limited medical benefits inherently conflicts with Michigan's no-fault act. Because the PPO endorsement at issue is inconsistent with the act, the commissioner was obligated to withdraw approval of the policy form incorporating the endorsement, pursuant to MCL 500.2236. The circuit court's reversal of the commissioner's decision was therefore not error.

Affirmed.

/s/ Janet T. Neff
/s/ E. Thomas Fitzgerald

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[12] In light of our resolution, we do not address the remaining issues and arguments of the parties. However, we note that petitioners' argument that pursuant to § 3157 providers are entitled to reimbursement of "reasonable amounts customarily charged for their services" fails in light of the recent decision in *Advocacy Organization, supra*. The statutory language in § 3157, referring to the amount the provider "customarily charges," is simply a cap on the amount health-care providers can charge. *Id.* at 374, 377. Providers therefore have no entitlement to be reimbursed their customary charges. Further, we reject any argument that the enactment or subsequent repeal by referendum vote of 1993 PA 143 is determinative in this case. That legislation made comprehensive changes to Michigan's no-fault insurance scheme. Because the referendum rejected the act in its entirety, it has little bearing on the disposition of this case. At most, it is arguable that the Legislature's substitution of the phrase "medically appropriate" services in Public Act 143 for the phrase "reasonably necessary" services in § 3107 of the existing act further supports the conclusion that the latter phrase is incongruent with managed care concepts.

STATE OF MICHIGAN

COURT OF APPEALS

MICHIGAN CHIROPRACTIC COUNCIL and MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners-Appellees,

v

COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE SERVICES,

Respondent-Appellant,

and

FARMERS INSURANCE EXCHANGE and MID CENTURY INSURANCE COMPANY,

Intervenors-Respondents.

FOR PUBLICATION
June 1, 2004

No. 241870
Ingham Circuit Court
LC No. 01-093481-AA

MICHIGAN CHIROPRACTIC COUNCIL and MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners-Appellees,

v

COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE SERVICES,

Respondent,

and

FARMERS INSURANCE EXCHANGE and MID CENTURY INSURANCE COMPANY,

Intervenors-Respondents-Appellants.

No. 241874
Ingham Circuit Court
LC No. 01-093481-AA

Before: Fitzgerald, P.J., and Neff and White, JJ.

WHITE, J. (*concurring*).

I join in the majority opinion, except Section IV A.[1] I write separately to make some additional observations.

The managed-care option at issue here is not expressly provided for by the no-fault act. Thus, it is permissible and enforceable if it does not reduce the coverage required by the act, and is impermissible and unenforceable if it does. *Cruz v State Farm Mut Automobile Ins Co.* 466 Mich 588; 648 NW2d 591 (2002).

Defendants argue that the managed-care option does not reduce the coverage mandated by §3107 because, through the managed system, all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation are covered. Acknowledging that this action was brought by provider groups, the dispositive inquiry in determining whether the endorsement violates the act is whether its enforcement results in the insured receiving less than the statutorily mandated coverage. Under the endorsement, the insured only receives the full benefits mandated by the act if services are obtained from a managed-care provider. If the insured, or a member of the insured's household, is injured and seeks a service from a non-managed-care provider, a deductible that exceeds the amount permitted under the statute is incurred, and the amount to be paid for the reasonably necessary service will not be the reasonable charge, as required by statute, but the amount under the carrier's usual and customary fee schedule. Stated differently, while the endorsement may provide the required coverage if the insured goes to a managed-care provider, it clearly does not provide the required coverage if the insured does not go to such a provider. This is a violation of the no-fault act.

Defendants argue that the no-fault system contemplates that the insured will have a free choice of providers, and that this aspect of the act is not violated because all that is done here is that the choice is made when the insurance contract is entered into, i.e., the insured agrees at that time that the insured will only seek services from certain providers. The insurer and the insured may agree to anything that does not reduce the coverage provided by the act. If the insured chooses to restrict his or her options in exchange for a premium reduction, and then after injury honors that choice, the statute is satisfied. However, if the insured chooses to seek reasonable services for a reasonable charge from a non-managed-care provider, and the insurer does not pay that charge, the no-fault statute has been violated. Thus, I conclude that the penalty provisions of the endorsement are illegal and unenforceable, and the commissioner should have withdrawn its approval. It is a separate question, not presented here, whether the endorsement would be valid if compliance after injury were voluntary on the part of the insured.

I also observe that in mandating that coordinated coverage be offered under the no-fault act, the Legislature acted against the backdrop of a regulated health insurance/managed health care industry. The laws pertaining to that industry evince a careful legislative balancing of the

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[1] I do not find it necessary to reach the issue addressed in that section.

sometimes conflicting interests of the insurers and plans, the health care providers, and the health care recipients. No such legislative controls are present here. An insured does not become a PPOM participant by choosing the PPO endorsement.

/s/ Helene N. White